

A Public Document

California Form 801

State of California, Managed Risk Medical Insurance Board (MRMIB)		Date Stamp 2008 SEP 18 PM 12:16 801	Form For Official Use Only
Division, Department, or Region (if applicable)			
Street Address			
1000 G Street, Suite 450, Sacramento, CA 95814			
Area Code/Phone Number	E-mail		
(916) 327-8011	(drushton@mrmib.ca.gov)		
Agency Contact (name and title)		<input type="checkbox"/> Amendment (explain in comment section)	
Diana Rushton, Filing Officer		Date of Original Filing: _____ (month, day, year)	

<input type="checkbox"/> Individual		<input checked="" type="checkbox"/> Other		Health Care Conf. Administrators (HCCA)	
Last Name		First Name		Name	
505 Montgomery Street, Suite 800		San Francisco		CA 94111	
Address		City		State Zip Code	

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

If applicable, identify the name of each source and the amount(s) solicited or received by the donor for this gift:

_____ \$ _____ _____ \$ _____
Name Amount Name Amount

Date and Amount of Payment *(other than travel)* 8/19-8/21/08 \$
(month, day, year) *(Round to whole dollars)*

Travel Payment Information *(Round to whole dollars)* **Location of Travel** _____

	\$	\$	\$ 220.00	\$	\$
Date(s) of Travel	Transportation Expenses	Lodging Expenses	Meal Expenses	Other Expenses	Total Expenses


Provide a specific description of the nature and use of the payment for official agency business:

Meals provided at a conference on health care privacy and security. (8/19-8/21/08)

Identify the officials for whom the payment was used:

[illegible]

I have determined that it is in the interests of the agency to accept this gift and use it for the official agency business described above.

	Lesley Cummings	Executive Director	9/5/08
Signature of Agency Head or Designee	Print Name	Title	(month, day, year)

Comment: (Use this space or an attachment for any additional information.)